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FOR ACTION

UNICEF/WHO JOINT COMMITTEE ON HEALTH POLICY

Report of the special session held at the headquarters of the World Health Organization

Geneva, 30-31 January 1992

The Executive Director recommends that the Executive Board note the present report and endorse the recommendations contained in paragraphs 23, 29, 42, 45, 52, 56 and 61.

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UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY **JCHP-SS/92.8**

Special session

Geneva, 30-31 January 1992

REPORT OF THE SPECIAL SESSION HELD AT THE HEADQUARTERS OF THE WORLD HEALTH ORGANIZATION

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I. INTRODUCTION

1. Dr Y. Kawaguchi, Director, Planning, Coordination and Cooperation, WHO, opened the session and welcomed participants. He called for nominations for Chairman and Rapporteurs.

2. Professor O. Ransome-Kuti (Nigeria), Chairman of the WHO Executive Board, was unanimously elected Chairman. Dr A. Manley (United States of America), member of the UNICEF Executive Board, and Professor M. Edjazi (Afghanistan), member of the WHO Executive Board, were elected Rapporteurs.

3. The Chairman observed that one of the dominant features of the recent session of the WHO Executive Board had been repeated references to the need to further strengthen collaboration within the United Nations system in order to ensure that everyone, particularly the most disadvantaged, did indeed achieve the goal of health for all. Within that system the UNICEF-WHO Joint Committee on Health Policy (JCHP) held pride of place in fostering collaboration between WHO and UNICEF to promote the well-being of women and children. Its current session should further enhance that collaboration and lead to practical action at the national level. He referred to the International Forum on Health: a Conditionality for Economic Development, which had been organized by WHO in collaboration with the Government of Ghana, in Accra from 4 to 6 December 1991. In its declaration, entitled the "Accra Initiative on Health", the Forum had recommended that in order to alleviate the global crisis in health status, health status should be given equal weight with other major criteria in assessing development strategies. Its proposals to link health activities to investment, income generating activities and economic enterprise could be seen as an integral part of the action required to implement the goals of the World Summit for Children.

4. Turning to the agenda for the meeting, the Chairman said that there were two important interrelated items: the follow-up action to be taken by WHO and UNICEF to support the implementation by countries of the Summit goals and the improvement of the health infrastructure, particularly the management of the district health system based on primary health care, which was essential to the achievement of those goals. He had supported the proposal to hold the extraordinary session of JCHP so that no time should be lost in advising the Secretariats of WHO and UNICEF on the most effective ways of collaborating at all levels, especially at the country level. The other two items on the agenda were related to breast-feeding - the "baby-friendly" hospital initiative, and UNICEF's role in promoting breast-feeding, particularly the issue of marketing of breast-milk substitutes. He was convinced that the meeting would be able to take appropriate decisions on those items.

5. The proposed agenda was adopted and is attached as Annex 1. The list of participants is given in Annex 2.

II. SUMMARY OF STATEMENTS BY THE DIRECTOR-GENERAL OF WHO AND THE DEPUTY EXECUTIVE DIRECTOR OF UNICEF

6. Dr Hiroshi Nakajima, Director-General of WHO, said that, since the twenty-eighth session of JCHP in January 1991, the map of Europe had undergone significant change and international attention was increasingly centred on Europe at the expense of developing regions and countries, which continued to languish under burdens of debt and consequent ill-health, under-development and, in some cases, natural disasters and civil strife. The world was facing a serious economic situation, with looming recession in developed countries. At the same time, the United Nations was being expected to play an increasingly important role in stimulating development, despite severe financial constraints.

7. A major item on the agenda of the eighty-ninth session of the WHO Executive Board, which had just ended - the second evaluation of the implementation of the Global Strategy of Health for All by the Year 2000 - had shown that substantial improvement had occurred in health status throughout the world, while at the same time highlighting the crucial importance of an integrated approach to public health. There was evidence of disparities in health status between the least developed countries and other developing countries, and of increasing disparities among certain population groups within countries. An epidemiological transition was also under way, with a growing prevalence of noncommunicable diseases, the rapid aging of the population, the reappearance of tuberculosis and malaria, and the more recent scourge of AIDS. Looking to the future, there was, therefore, an obvious necessity for health professionals and others to confront reality in its multiple dimensions - political, economic, social and technical. For that reason, he was proposing a paradigm for new

public health action, which called for an analysis of current realities to provide a basis on which to support countries in finding solutions to their health and development problems. So far, not enough had been done in studying carefully the effect on health of socioeconomic development, in admitting the power of economic and political issues in bringing about and sustaining change, in anticipating the special needs of vulnerable and socially and economically deprived groups, in involving individuals, families, communities, local nongovernmental organizations and health personnel, and in strengthening managerial capacity. Four main directions were proposed within the paradigm: (1) a holistic model for the protection and promotion of human health, seen in a physical, social, behavioural and ecological context; (2) renewed efforts in providing health care for all by bringing support to countries and population groups in greatest need; (3) the development of adequate human and other resources to ensure health; and (4) greater emphasis on monitoring and evaluation of the effectiveness and efficiency of public health action within a multisectoral setting. That enormous challenge was accompanied by a great opportunity to make the role of all the components of the United Nations system more visible in social and economic development, using health to attract and maintain support from the international community.

8. JCHP could assist in that respect by focusing on what could be done immediately to promote the health and well-being of women and children, while, at the same time, keeping its long-term goals and strategies clearly in view, in order to foster continuity and sustainability. JCHP currently had before it a number of suggestions concerning collaborative action in relation to implementation of the declaration and plan of action of the World Summit for Children, and also to the strengthening of health infrastructure, particularly through improved management of district health systems as the critical pivot on which community mobilization, participation and involvement as well as community empowerment turned. As the WHO Executive Board had emphasized, there was a need to develop a stronger health infrastructure, particularly in developing countries, with priority being given to the strategy for intensifying cooperation with countries and peoples in greatest need.

9. In conclusion, it was essential to maintain excellence in the face of challenge and to defend the principles of ethics and human rights on which public health programmes were founded, while at the same time maintaining a balance in the current, fast-changing world, so that energies and resources were expended on an equitable basis. He referred in that context to the recently established WHO/UNICEF coordinating role in providing medical assistance for the former Soviet Union and to joint efforts to alleviate suffering, particularly among women and children, in the Middle East. WHO and UNICEF were currently in the frontline of United Nations humanitarian assistance efforts, for which they were investing their capabilities and making optimum use of limited resources within their mandated activities. He looked forward to the JCHP's advice and recommendations on strengthening activity in terms of policy development and implementation.

10. Dr R. Jolly, Deputy Executive Director of UNICEF, apologized for the absence of Mr James P. Grant, Executive Director of UNICEF, who had been called away at short notice. He endorsed the remarks of the Director-General of WHO concerning the special nature of the current JCHP meeting, in view of the many events and changes which had taken place in the world over the past 12 months. As the new United Nations Secretary-General had emphasized, recent developments and progress in the political arena must be taken forward into the economic field in the 1990s.

11. Four specific examples underlined the new opportunities which had opened up: first, the much greater awareness that human development was of central importance; secondly, the new determination to put more resources into that area; thirdly, the potential of the peace dividend; and, fourthly, the Accra Initiative which gave a particular focus to health.

12. The follow-up to the World Summit for Children was increasing, with 150 countries having signed the declaration and thus committed themselves to preparing national programmes of action to implement the goals of the Summit. Already UNICEF had received 25 national programmes of action and had been advised by 75 other governments that national programmes were in preparation. In addition, mobilization was evident in a number of key fields, as the meetings on micronutrients, acute respiratory infections, "baby-friendly" hospitals and education, in cooperation with UNESCO, indicated.

13. Finally, JCHP had played a vital role in the past; it had, for instance, provided the major focus for working out breast-feeding goals and the follow-through for the policy framework of primary health care and district level health activities. Generally speaking, JCHP served as a forum to clarify issues and identify the

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way forward. He recalled in that connection that it had been informally during the course of the 1991 meeting that details had been worked out for joint UNICEF/WHO medical assistance in Iraq. It should be borne in mind for the future that far-reaching goals, such as the eradication of smallpox, were attainable when people turned their minds and energies to achieving them. Challenges, which had proved to be constructive for both organizations in the past, could assist in providing a way forward in the future.

III. WORLD SUMMIT FOR CHILDREN: FOLLOW-UP ACTION

14. Introducing the agenda item, the Chairman recalled that JCHP had recommended to the World Health Assembly and to the Executive Boards of WHO and UNICEF that they should direct their respective organizations to develop implementation plans in pursuance of the goals enunciated in the declaration and plan of action of the World Summit for Children and continue their collaboration in the complementary planning of actions which the two agencies were to undertake on a collaborative basis to that end during the decade of the 1990s. The document before JCHP[1] was the response to that recommendation. It contained three principal sections - an executive summary and Parts I and II, containing respectively, the more detailed contributions of WHO and of UNICEF to the follow-up action. The WHO contribution included all the 21 goals directly related to the health of women and children, out of a total of 27 contained in the World Summit plan of action, together with essential or supporting programmes and also wider concern for the health of youth with which UNICEF had become involved in recent years. The approach in the WHO section was its support to countries in developing programmes corresponding to their special national needs, particularly in areas such as planning, training and supervision, strengthening health infrastructure, monitoring and evaluation, research and development. Part II, which contained UNICEF's contribution, discussed the goals for children and development in the 1990s in the framework for action, the setting of priorities, and the phasing of strategic programme actions. The programme areas outlined in Part II were similar to those stressed in Part I, but Part II also addressed the question of universal primary education, with a special emphasis on the girl child, as well as children in difficult circumstances. An addendum to Part II outlined priority points for collaboration between UNICEF and WHO which had been taken into account in the executive summary. There were also two background papers to be considered simultaneously with the major paper, one on meeting vaccine needs for the EPI in the 1990s[2] and the other on response to the cholera epidemic.[3] JCHP was requested to consider the proposals outlined in the executive summary of document JCHP-SS/92.2 and how best WHO and UNICEF might cooperate to meet countries' needs in specific programme areas.

General discussion

15. Discussion focused on the implications of the current rapid changes in the world and the economic difficulties experienced by developing countries in sustaining health infrastructure and continuity in health programmes.

16. UNICEF/JCHP members pointed to the need for urgent action, citing the time required to establish national primary health care systems in countries. Such systems were essential but they could become too bureaucratic. They should be decentralized with increased community participation and the resources of both organizations should be focused on the district level within an integrated health system.

17. It was pointed out that women and children often had access to only 10%-20% of the meagre health care facilities available in developing countries, the greater share being enjoyed by more powerful groups. Key areas which should not be neglected include: immunization, chronic protein energy malnutrition among girls, low birth-weight, micronutrient deficiency, population growth and gender discrimination. Family planning goals and nutrition targets should be essential constituents in programmes funded by WHO and UNICEF. The programmes on acute respiratory infections (ARI) and oral rehydration therapy (ORT) could follow the targeted approach adopted by the Expanded Programme on Immunization (EPI). There was also the potential for common action to support countries in the development of programmes, such as eradication of poliomyelitis, taking into account priorities of the Summit. In addition, the health status of women should not

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[1] Document JCHP-SS/92.2.

[2] Document JCHP-SS/92.3.

[3] Document JCHP-SS/92.4.

be considered only in terms of their reproductive role; the aim should be to achieve a global positive impact on their status with respect to work, education, sex ratios, and decision-making in the household, as well as access to health services.

18. JCHP noted that the World Summit had laid particular stress on the need for a priority commitment to Africa. The very rapid changes currently taking place in various parts of the world often make it difficult for the agencies to keep abreast of events, and children are frequently the chief sufferers from the rapidly evolving world situation. There is a clear need to mobilize additional resources. Approaches used by WHO and UNICEF do not necessarily need to be traditional ones. The Bamako Initiative is providing insight into approaches for helping to solve the problems of children in the African Region. The desirability of collaborative programming was discussed, with the potential for more efficient use of available resources.

19. Attention was drawn to the differences between the two agencies, their respective strengths and weaknesses, and their contrasting approaches. Some members characterized UNICEF as moving somewhat more swiftly to analyse and tackle problems through the skills of social scientists, economists and managers, and through its experience in advocacy, and saw WHO as having moved more slowly both in the mobilizing of resources and in the more complicated task of helping countries establish national policies, programmes and activities. They stressed the need to bring the expertise and skills of the two agencies together so that they could complement each other. Other JCHP members felt that it was better not to try to compare the two institutions, which were carrying out different but complementary tasks. However, there was agreement that it was essential for both to work together and to agree on common approaches. WHO/JCHP members pointed out that the division of labour, i.e., complementarity of efforts between the two bodies, was in fact determined by those actually working in the field. WHO was active at country, local and community levels. The relationship between the two agencies was particularly intimate, for example, in the African Region, where there were seven joint WHO/UNICEF working groups, and these were joined by representatives of FAO when nutrition-related matters were under discussion.

20. Concerning the areas to be given priority attention by WHO and UNICEF in strengthening national health systems, there was agreement that, where training and supervision were concerned, training by itself was not enough to ensure that staff with the required skills would be produced. Training would need to be supported by a system of incentives and disincentives, possibly including legislation. It was pointed out that training was one of the areas in which the activities of the two agencies were already closely harmonized at country level. While UNICEF uses WHO materials in training programmes for traditional birth attendants, immunization and diarrhoeal disease control, these materials may be adapted to specific countries. A distinction between the two organizations is that UNICEF training focuses more on the community level, whereas WHO gives more emphasis to training at the national level.

21. The need for greater community involvement was emphasized. Community participation should include nongovernmental organizations and the private sector. Increasing resource limitations highlight the importance of effective community participation in planning and implementing programmes which would assist in solving their perceived problems. Involvement of the community in management is also crucial. UNICEF's field work has been successful in the areas of social education, communication and mobilization. However, many developing countries continue to be faced with the practical problems of inadequate infrastructure and scarcity of resources. Infrastructure in the form of the interface between the health worker and the household at the local level should be improved and extended.

22. In conclusion, general agreement was expressed with the strategies outlined for joint WHO-UNICEF action, with each organization drawing upon its areas of strength and comparative advantage.

23. **Recommendations**

(1) The principal action to be supported by WHO and UNICEF is the **strengthening of the national health system** with a focus on the district health system based on primary health care. JCHP recommends that priority attention be given to:

(a) **training and supervision** of all categories of national personnel with an emphasis on the team approach;

(b) **logistics and supplies** in particular drugs, vaccines and other needs (on which programmes such as the Expanded Programme on Immunization, the Global Programme on AIDS, as well as programmes on diarrhoeal diseases, acute respiratory infections, malaria and schistosomiasis depend); this requires intensified use of the Action Programme on Essential Drugs, the Bamako Initiative, other community-based initiatives, and UNICEF's field operation support system;

(c) **community and health education** to serve the interests of all programmes by creating public awareness and supplying the basic knowledge people need to take charge of their own health, a critical factor for example in the prevention and control of AIDS - extensive promotion of the booklet, *Facts for Life*,[1] will empower families to improve their health and strengthen linkages between the community and local health services;

(d) **community involvement and empowerment** to ensure people's full participation in planning for and meeting their own needs;

(e) **surveillance, information gathering, monitoring and evaluation** with the aim of strengthening national epidemiological capacity to enhance the delivery of strategies, better manage the supply line, and more effectively monitor impact and quality control at all levels of the health system, in particular the district health system, as well as within each programme area; the crucial element to be promoted is routine information exchange to obtain and feed back regular assessments of programme progress as well as suggestions from health workers about solving operational problems;

(f) **biomedical and operational research** to harness science to improve the available tools to strengthen the biomedical research required to ensure the highest possible technical standards, and to meet the management needs of the system.

(2) JCHP recommends the following specific programme areas, among others, for collaboration between WHO and UNICEF in support of countries:

(a) **reduction of infant and child mortality** - ensuring that in all activities related to reduction of infant mortality there is (i) better application of epidemiological principles and methods; and (ii) the screening of every child brought to a health clinic for any reason, and the linkage of care to ensure that the other elements of health promotion, protection and care are provided;

(b) **women's health, safe motherhood and newborn care** - (i) extending technical cooperation in the development of national programmes for maternal and neonatal health within primary health care, and encouraging national programmes to establish a focal point for the programme; (ii) research on the organization of maternal health services, and on interventions and programme management of specific conditions such as postpartum haemorrhage and anaemia, unclean delivery/obstetric sepsis, hypertensive diseases of pregnancy, and unwanted pregnancy and unsafe abortion; (iii) training and community education in the context of the district health system; and (iv) the analysis of data from various data bases on maternal and newborn health to be issued periodically to facilitate advocacy and information dissemination;

(c) **Expanded Programme on Immunization (EPI)** - (i) developing overall immunization plans of action within primary health care through the formation and strengthening of technical advisory groups at regional and country level; (ii) training in the management of immunization programmes and disease surveillance and control to strengthen the managerial capacity for implementing primary health care activities; (iii) research on improved disease control strategies, improved methods and materials for diagnosis of the EPI target diseases, improved surveillance and programme monitoring tools, and improved methods and materials for the cold chain and logistic support; (iv) ensuring the supply of vaccines including new vaccines, as well as the quality of vaccines, in the face of increasing costs;

(d) **diarrhoeal diseases** - (i) mobilization and advocacy at the highest political level; (ii) promoting correct home management of diarrhoea; (iii) training at all levels of the health system with special

[1] Joint UNICEF, WHO and UNESCO publication, available from UNICEF, New York.

emphasis on four-day clinical training courses at health centres and small hospitals; (iv) establishing oral rehydration therapy units; (v) ensuring availability of oral rehydration salts; (vi) improving communications - both interpersonal and by way of the mass media and health education; (vii) evaluation through health facility surveys, household surveys and programme reviews; and (viii) prevention, including promotion of breast-feeding, especially exclusive breast-feeding for the first four to six months of life, measles immunization and personal and food hygiene;

(e) **acute respiratory infections** - case management is the essential strategy to avert pneumonia deaths and make an immediate impact on mortality from acute respiratory infections; WHO and UNICEF will concentrate their support to countries on (i) sound technical and managerial policies and planning, including measures which will enable control activities to reach the people; (ii) training in all these aspects; (iii) ethnographic studies to serve as the basis for local adaptation of generic communication messages; (iv) development of a checklist for supervision of case management; (v) ensuring supplies particularly through the essential drugs programme and the Bamako Initiative; (vi) monitoring and evaluation of programme activities and health systems research;

(f) **nutrition** - WHO/UNICEF collaborative activities include supporting countries (i) to develop and strengthen national nutrition policies; (ii) to combat deficiencies in iodine (in order to eliminate goitre, cretinism and related disorders), vitamin A deficiencies (to combat blindness) and iron deficiencies (to fight nutritional anaemia); (iii) to bring protein-energy malnutrition under control through strategies to ensure household food security, correcting inappropriate feeding practices (particularly in women and children) and to prevent and manage infection and parasite infestation, with a special focus on least developed countries and pockets of poverty in others; (iv) to develop national nutritional surveillance capabilities, strengthen nutrition-related information, education and training, and foster nutrition research;

- an action plan emanating from the major international conference on micronutrient malnutrition jointly convened in October 1991, in Montreal, had been drawn up for presentation to the WHO Executive Board[1] and the World Health Assembly in 1992: WHO and UNICEF will support country efforts leading to virtual elimination of Vitamin A deficiency and iodine deficiency diseases and significant reduction of iron deficiency anaemia; jointly sponsored workshops on micronutrient deficiencies will also be convened at the regional level;

(g) **breast-feeding** - common actions include: (i) advocacy and health education adapted to sociocultural settings; (ii) development of education and information materials; (iii) promoting lactation management and breast-feeding training through a regional network of training centres; (iv) encouraging the provision of social support for breast-feeding women; (v) technical support for the national application of the International Code of Marketing of Breast-milk Substitutes; (vi) operational research, in particular to facilitate the achievement by all women of the infant feeding ideal set out in the Innocenti Declaration;

- the joint launching and support given to the WHO/UNICEF "baby-friendly" hospital initiative provides a focus and starting point for country and community-based action on many of these activities; promotion and support of the concept of "baby-friendly" hospitals should result in their establishment all over the world by the end of 1992;

(h) **water and sanitation** - the WHO/UNICEF Joint Monitoring Programme for the Water and Sanitation Sector was signed in March 1990; data relevant to the achievement of the World Summit goals are to be obtained from studies on rural and urban populations with access to safe water supply and sanitation, and on utilization of these systems especially by low-income groups; the Joint Monitoring Programme is planned to be implemented throughout the 1990s with the initial seven countries acting as regional focal points;

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[1] Document EB89/20.

(i) **dracunculiasis (guinea-worm disease)** - WHO and UNICEF will continue to work together to improve and implement: (i) community surveillance methodologies; (ii) vector control strategies; (iii) case containment strategies; (iv) mapping of remote villages; (v) strategies for targeting and monitoring the impact of water supply;

(j) **malaria control** - collaborative efforts will continue in many endemic countries: (i) to identify those populations at risk to malaria and to improve the diagnosis and management of the disease, particularly severe and complicated cases; (ii) to support operational research on the efficacy of impregnated bednets; (iii) to provide intensified support in health education, the provision of essential supplies and in social mobilization;

- concerning prophylaxis which is still desirable in pregnancy, it is necessary to weigh the risks and benefits of the drug available in each local situation; the Ministerial Conference on Malaria (Amsterdam, 26-27 October 1992), organized by WHO and supported by UNICEF, will indicate new areas for intensive collaboration;

(k) **schistosomiasis** - (i) the pricing structure of the drug praziquantel is being negotiated with manufacturers, and it is anticipated that UNICEF will participate with WHO in this endeavour; (ii) UNICEF-supported water supply programmes will also be encouraged to consider schistosomiasis as a health monitoring indicator wherever appropriate;

(l) **essential drugs** - (i) continuing collaborative operational research activities including drug stability during international transport; (ii) the WHO Action Programme on Essential Drugs will continue to work with UNICEF to establish community-based projects supported by strong drug-sector infrastructures; (iii) the Programme in collaboration with UNICEF will continue, through information campaigns, to help educate health care providers and the public in general in the rational use of drugs and will strengthen in particular the capacities at the district level through training in drug management, rational use and monitoring;

(m) **prevention and control of AIDS** - (i) worldwide advocacy for implementation of AIDS prevention and control activities by many sectors and ministries; (ii) adoption of quantitative programme goals in order to achieve the reduction of infant and child mortality called for by the World Summit; (iii) educational programmes for youth, both in and out of school, emphasizing safer sexual behaviour and the use of condoms as the main preventive strategy; (iv) social and economic support to children orphaned as a consequence of AIDS, especially in sub-Saharan Africa; (v) collaboration on research and development of vaccines and on interventions to reduce female vulnerability; (vi) using the Bamako Initiative to provide essential drugs for treatment of sexually transmitted diseases and opportunistic infections;

(n) **healthy life-styles for youth** - (i) collaboration with other organizations such as UNFPA and youth nongovernmental organizations to promote policies and programmes for adolescent health in a variety of international forums; (ii) development of a strategic, long-term plan for joint country activities to be implemented using the integrated, intersectoral and interagency approach recommended by JCHP; (iii) initiation of a joint pilot training programme in three countries for personnel working with street children to better deal with the problems associated with substance abuse.

Monitoring and evaluation

24. The Committee focused on the issues surrounding monitoring of the World Summit goals, specifically the 21 health goals set out in the plan of action.

25. Attention was drawn to the fact that WHO and UNICEF are already collaborating closely on the immediate action to be taken. A series of indicators has been identified for monitoring the implementation of the World Summit health goals, and the need for support to country monitoring was recognized. Data collected must be useful to managers and policy-makers, not just for monitoring as an end in itself. The selection of health indicators for mid-decade monitoring should be ones for which data can realistically be collected by countries. It was suggested that the same core list of health indicators should be used for monitoring both health-for-all targets and World Summit health goals. WHO strongly encouraged cooperation

between the two organizations in providing support for countries in their monitoring efforts, and the next steps to be taken were discussed and agreed upon (see paragraph 29, recommendation 2, below).

26. The Director of the Global Programme on AIDS reminded the Committee that the AIDS pandemic will make it difficult to attain some of the World Summit goals. It is now estimated that the number of new HIV infections per year in Asia will overtake that of Africa in 1996-1997, earlier than had been thought. It is important to realize that such developments would hamper the attainment of the World Summit goals, and it would be desirable to include an indicator on how certain countries were dealing with the AIDS problem, since the present indicators for health-for-all and World Summit goal monitoring have clearly been superseded by this phenomenon. The Global Programme on AIDS will have a standard set of global indicators ready by the end of 1992.

27. The Deputy Executive Director of UNICEF drew attention to the importance and technical and political complexity of monitoring, because of the many different bodies and levels involved. UNICEF welcomed the emphasis laid in the background paper[1] on national action and close collaboration with all the organizations involved. He encouraged more emphasis on the evolution of approaches and on the need for good indicators which can be applied to different levels and take into account different rates of development. The gender dimension should be stressed more strongly, as was the case in the World Summit goals. It was emphasized that the World Summit goals go beyond the health sector, and this must be taken into account in monitoring progress toward them.

28. It was also noted that ministries other than health ministries are involved in monitoring the World Summit goals. The health portion of monitoring for the mid-decade review should, however, be generated through the health-for-all monitoring process.

29. **Recommendations**

(1) JCHP recommends that **immediate action** be taken on the following in areas relating to health, taking into account the discussion in the Committee:

(a) the responsible technical programme in WHO, in consultation with counterparts in UNICEF, to confirm the definitions of proposed indicators related to each health goal;

(b) UNICEF and WHO to identify and agree upon the set of core primary indicators to be initially used for global monitoring;

(c) prepare a monitoring guideline to be issued, which, as a minimum, should contain: (i) the agreed principles for monitoring the World Summit goals; (ii) the criteria for acceptable indicators; (iii) the current list of proposed indicators giving for each the agreed technical definition, the recommended sources of data and methods of data collection; (iv) the list of types of country level collaboration which UNICEF and WHO can jointly provide from country, regional, and global levels;

(d) strengthen collaboration with the United Nations Statistical Office, UNDP and UNFPA by broadening a proposed project for monitoring social (human) development beyond household survey methods to include a variety of data sources, and the involvement of a number of agencies in a coordinated manner; a special effort to develop and document methods for measuring mortality and its causes should be included in this proposal, for implementation by the WHO programme on epidemiological surveillance and health situation and trend assessment;

(e) coordinate monitoring methods development with the World Bank programme on social dimensions of adjustment and the USAID demographic and health survey activity;

(f) compile a description of indicator data bases maintained by various programmes in WHO, Geneva, and UNICEF, New York, to facilitate data sharing and to reduce duplicate data base maintenance;

[1] JCHP-SS/92.2 Executive Summary.

(g) compile and share a schedule of global, regional and country level meetings and workshops on the subject of monitoring and evaluation to be convened by either or both organizations.

(2) JCHP recommends that the **next steps** might be: (1) to finalize jointly the choice and definition of core indicators; (2) to produce jointly monitoring guidelines for the country offices of both organizations; (3) to identify country and regional workshops for training staff and nationals and coordinate the staff and financial support for those workshops; (4) to identify specific countries requiring special efforts for the establishment of baseline data for which support is needed; and, (5) to strive to assure that the national input to the health aspects of the mid-decade review be accomplished through the 1994 HFA monitoring exercise in order to minimize national reporting burdens and that the guidelines for that report be prepared together with UNICEF.

IV. MEETING VACCINE NEEDS FOR THE EXPANDED PROGRAMME ON IMMUNIZATION IN THE 1990s

30. The Committee discussed the background paper entitled "Meeting vaccine needs for the EPI in the 1990s".[1] EPI is facing a crisis. Not only are greater resources required for procurement of vaccines, owing to rising prices, but more vaccines are needed to carry out programmes to achieve immunization goals. Over the past few years, EPI has developed from a routine immunization programme into various disease control initiatives requiring larger volumes of vaccine, notably the poliomyelitis eradication strategy and the strategy to eliminate neonatal tetanus by protecting all women of reproductive age.

31. At the same time, vaccine manufacturers are requiring more capital expenditure to expand production capacity. Many manufacturers are being bought up by multinational pharmaceutical corporations, which means that they have to compete for resources with pharmaceutical producers within the same corporation. Indeed, manufacturers claim that the narrow margins in the UNICEF/WHO/PAHO portion of their markets preclude a sufficient return on investment, and that they need to raise prices in order to generate sufficient profit to justify continued capital investment support from their companies in a highly competitive environment. A further factor is that Rotary International, which has hitherto provided poliomyelitis vaccine for much of the developing world, is reducing its contribution for vaccine procurement because of resource constraints, having fulfilled its commitment to provide free vaccines for a five-year period. In addition, Eastern Europe and the former Soviet Union are having difficulties with continued production, so a formerly self-sufficient area of the world might soon become a net importer of vaccines, putting further pressure on the stocks available for developing countries.

32. Another cause for concern is the need to ensure the quality of the vaccine produced. The facility to provide quality control is also needed in the case of vaccines imported into developing countries from industrialized countries.

33. Reference was made to resolution EB89.R8, adopted by the WHO Executive Board in January 1992, which draws attention to difficulties in the supply and procurement of high quality vaccine and the need for additional funds for vaccine purchase, and urges Member States to commit the necessary resources to achieve the immunization goals and operational targets set for the 1990s. The resolution also calls on organizations of the United Nations system and other intergovernmental agencies to promote efforts to ensure the universal use of vaccines meeting WHO requirements, and to work with donors to ensure the increased financial support necessary to meet both current and future vaccine needs.

34. The Committee was given a description of the success achieved in WHO's Western Pacific Region in reaching the EPI goal for 1990 of 80% coverage of children reaching one year of age. The reported number of cases of EPI target diseases were at the lowest levels since the start of data collection. In 1988, the number of poliomyelitis cases in the Region had fallen to 1927, and the Regional Committee had adopted a resolution to eradicate the disease by 1995. Although there had subsequently been a rise in incidence, it had since fallen from 5963 cases in 1990 to only 2541 in 1991.

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[1] Document JCHP-SS/92.3.

35. The countries concerned had recognized that health services could reach all children, that prevention was necessary and beneficial, and that there was a cost-benefit trade-off in disease eradication programmes, and they had therefore concluded that it was unacceptable for even one child to be crippled by poliomyelitis. They were also aware that eradication would strengthen EPI and foster its contribution to the development of health infrastructure and primary health care. To achieve that goal, all countries in the Region had developed national programmes that were being vigorously implemented. As a result, the Region is confronted with the consequences of success. Additional resources are now needed, particularly poliovirus vaccine. For 1992, there will be a shortfall of some 290 million doses of oral polio vaccine for supplementary immunization activities in the Region. For 1993, 1994 and 1995, an additional 340 million doses will be needed annually; and to provide that, some US$ 91 million will have to be mobilized for the four-year period, 1992-1995. No doubt research will lead to cheaper methods and vaccines but, in the meantime, the proven vaccines and technologies will have to be used. The lessons learned during poliomyelitis eradication might themselves eventually reduce vaccine requirements, as was the case for smallpox eradication after development of the surveillance and containment strategy and the introduction of the bifurcated needle.

36. The need for improved disease surveillance is a common theme in the EPI and disease control initiatives, and indeed in all primary health care activities. With better data, efforts could be focused on increasing coverage and on providing supplementary immunization only in those areas requiring it, thus economizing on resources. A surveillance system for poliomyelitis has been established and it will be strengthened to cover other target diseases. The Western Pacific Region has led the way in increasing and sustaining EPI immunization coverage and in adding new antigens, such as hepatitis B. They are now ready to lead the way in achieving the disease control targets, but for that they need additional resources, especially vaccine. The countries concerned are increasing their national level of support for those activities, but further support is needed from all Member States, from UNICEF, from Rotary International and members of the international community. Such support would make it possible to sustain and build on what has been achieved, and to meet the increased expectations arising from the success of EPI.

37. The EPI experience in China, where national immunization with each of the antigens had reached well over 90%, was also described. Incidence of the EPI target diseases was at an historical low, with the exception of poliomyelitis, which had increased slightly in 1989-1990, mainly among the small percentage of unvaccinated children. China was grateful for support provided for EPI and disease control initiatives led by WHO, UNICEF and other agencies: however, the larger part of expenditure was being borne by the country itself. China had set itself the goal of eradicating poliomyelitis by 1995, five years before the global target date. Unless it could obtain more vaccine, it risked losing momentum. Thus support from the international community was needed to provide the additional 1.1 thousand million doses of polio virus vaccine required over a five-year period, which would cost some US$ 77 million at 1991 prices.

38. From the UNICEF side, it was stressed that because of the radical change in the vaccine supply situation, both agencies needed to establish a coherent strategy for long-term supply which would cover quality, security and price. If the agencies were to be in a stronger position *vis-à-vis* the suppliers, there would have to be a change in the contracting regime. Research carried out under the Children's Vaccine Initiative might lead not only to improvements in quality and types of vaccines, but could also extend shelf-life and decrease the number of doses required, which would have an impact on the costs of overall programmes. Both agencies should help countries to define costs in some detail, since some countries might not be in a position to reach all the goals set by the World Summit. Thus meaningful choices could be made as to what could be achieved within the limits of financial constraints.

39. Some JCHP members expressed concern over the capacity of some countries to achieve self-sufficiency in vaccine production, and urged great caution in pushing countries too rapidly to become self-sufficient producers or to rely solely on the Vaccine Independence Initiative financing mechanism. The WHO Secretariat expressed the view that alternative mechanisms to national vaccine quality control bodies might be employed to good advantage. It was suggested that WHO and UNICEF should facilitate support to countries with the necessary machinery, expertise and capital to enable them to produce vaccines for themselves, with due caution about quality control.

40. It was also pointed out that the question of vaccine quality had been of concern to both agencies for some time, and there was already an established procedure for evaluating the quality of supplies. Under that procedure, not only the quality of vaccines produced by manufacturers who wished to sell to UNICEF, but also

the capability of the national licensing authority was evaluated by a group of independent experts. WHO thought it important that it should not become a kind of supranational control authority, and therefore made use of independent experts for that evaluation. Recently, WHO had approved activities to evaluate the quality of vaccines being made in countries outside the UNICEF procurement system, which had been identified as needing help in strengthening the quality assurance of their products. Often it was management capability, rather than technology, which was lacking. For some smaller countries, the system used in industrialized countries to assess quality by duplicating the manufacturers' quality control activities would be an unnecessary burden, and for such countries efforts were being made to establish a system of regional cooperation which would make use of existing expertise in other countries to ensure quality.

41. With respect to quality control, JCHP requested that a plan of action be developed for 1992 and a progress report presented to the next meeting of JCHP.

42. **Recommendation**

JCHP expressed concern about the potential shortfall of high-quality vaccines for national immunization programmes. The WHO and UNICEF Executive Boards and governing bodies should consider urgent action on the following strategies to avert this emerging crisis:

(a) support to countries which have the capacity to produce vaccines, noting the national commitment and managerial resources required to produce high-quality vaccines, to become self-sufficient, including support to national control authorities to ensure that such locally produced vaccines are of high quality;

(b) soliciting the support of the donor community to provide greater resources for the procurement of high-quality vaccines for EPI, as well as to consider ways to encourage vaccine producers to provide vaccines at lower prices;

(c) facilitating, through the Vaccine Independence Initiative, the procurement of high-quality vaccines on behalf of governments, either with convertible or local currencies;

(d) establishing the supply of much greater quantities of vaccines of assured quality through current and/or new sources;

(e) utilizing the Children's Vaccine Initiative to help make the use of vaccines more effective (by developing products that are heat stable, involve fewer doses, less wastage and longer shelf-life, and have higher efficacy, etc.), to strengthen the epidemiological capacity to guide use of vaccines, to strengthen capacity to assure quality of current and new vaccines, and to develop and strengthen mechanisms for the supply of vaccines;

(f) reviewing possible mechanisms for establishing multi-year contracts for vaccine purchase.

V. RESPONSE TO THE CHOLERA EPIDEMIC: POINTS FOR ACTION

43. In introducing the background paper,[1] it was pointed out that cholera was still continuing, notably in Latin America and Africa, although it was attracting less media attention. It should be noted, however, that at least six countries in Latin America reported 50% of their cholera cases in the last few months of 1991, so that it would be incorrect to assume that the epidemic in that continent was fully controlled. In Africa in 1991, 20 countries reported 24% of all the world's cholera cases and 71% of the deaths. In response to the situation in 1991, the Director-General of WHO established the Global Task Force on Cholera Control, and some WHO regional offices also established task forces. Policy and control guidelines have been disseminated and WHO is continuing to work on intercountry coordination, technical cooperation with countries, resource mobilization and so forth. UNICEF has also been active, particularly in providing support to countries. Three action areas are described in the background paper: (i) emergency assistance, requests for which were bound to arise in 1992 and future years in connection with case management, water supply, sanitation, food safety, etc.; (ii) cholera preparedness in countries which have not yet experienced outbreaks of the disease and in those

[1] Document JCHP-SS/92.4.

where it occurs seasonally, assistance being provided primarily through the strengthening of diarrhoeal disease control programmes; and (iii) cholera prevention, in the form of assistance with long-term investments in water supply, sanitation, food safety and other aspects of hygiene. In 1991, despite the publicity given to cholera, neither organization had received enough additional resources to increase its activities significantly in that area, and in 1992 strategies would be jointly explored for increasing financial resources available to respond to countries' needs. The arrival of the epidemic in Latin America served as a very vivid reminder of the links between health and general development, particularly with respect to water supply and sanitation. The high case fatality rates of cholera in Africa, approximately 10%, show that many populations still have no access to effective diarrhoea case management. Whereas 500 000 cholera cases were reported to WHO in 1991, there were at any time at least 10 times that number of children suffering from diarrhoeal diseases; 18 000 deaths from cholera were reported to WHO in 1991, which was about the same number as deaths from other diarrhoeal diseases in 2-3 days. It would therefore be desirable to exploit the interest and concern generated by cholera in 1991 to obtain more resources and effort for diarrhoeal disease control programmes.

44. In the ensuing debate, stress was laid on the need for rapid action in response to requests for emergency assistance, on the use of the publicity and government concern engendered by cholera outbreaks to arouse greater interest in diarrhoeal diseases control programmes, on the particular need for cholera prevention, and on the fact that cholera, like other diarrhoeal diseases, could not be eradicated while the present tragic lack of infrastructure prevailed in the developing countries. Improvement of basic water supply and sanitation require sustained political will, a great deal of money and a long time.

45. **Recommendations**

(1) JCHP recommends that WHO and UNICEF assist governments in providing emergency responses to cholera outbreaks by:

(a) establishing intersectoral national cholera control committees;

(b) conducting initial assessments and identification of high risk groups;

(c) developing effective surveillance systems to detect outbreaks and track the spread of the disease;

(d) supporting measures to disinfect water supplies, identify and control likely major sources of food-borne spread, disseminate key health education messages to affected populations and restrict access to contaminated areas;

(e) establishing/training mobile teams to organize initial activities in newly-affected areas, e.g., set up emergency treatment centres;

(f) assessing emergency supply needs, procuring these supplies and ensuring timely distribution, e.g., of oral rehydration salts, intravenous fluids, utensils, antibiotics and laboratory supplies;

(g) involving community organizations in all phases of emergency action, especially in health education and the setting up of emergency treatment centres.

(2) JCHP recommends that WHO and UNICEF assist governments to achieve cholera preparedness by:

(a) incorporating cholera control as part of the national diarrhoeal diseases control programme as well as part of five-year programmes of cooperation;

(b) including cholera control activities as part of the diarrhoeal diseases control component of UNICEF country programmes;

(c) promoting broad-based community involvement in all aspects of cholera control and prevention, thus empowering communities to respond rapidly and effectively, e.g., through the establishment of community oral rehydration units in cholera-prone areas and among vulnerable groups;

(d) planning and implementing broad-based health education efforts (through media, schools and other channels) geared toward correct treatment, controlling transmission and preventing cholera incidence;

(e) consolidating improvements in surveillance, laboratory and reporting systems, which result from experience in controlling cholera outbreaks;

(f) assessing supply needs, procuring supplies and ensuring timely distribution, especially to particularly cholera-prone areas.

(3) JCHP recommends that WHO and UNICEF assist governments in cholera prevention by:

(a) developing comprehensive plans for improved water and sanitation systems;

(b) training food handlers and establishing good manufacturing practices in food processing plants;

(c) further strengthening health education efforts to promote improved personal, domestic, community and food hygiene practices;

(d) further improving case management of all diarrhoea episodes, both at home and within health facilities;

(e) continuing to expand the number and range of oral rehydration therapy providers both within and outside the health system;

(f) supporting key research projects related to cholera control, e.g., the development of a cholera vaccine, improved formulations of oral rehydration salts, simple tools for investigation of outbreaks, etc.

VI. MANAGEMENT OF THE DISTRICT HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE

46. The background document[1] was introduced with the comment that it represented an assessment of action being taken and suggested strategies which countries, with the support of WHO and UNICEF, could implement in order to enhance the implementation of primary health care. The following three points were highlighted. (1) The district focus would increasingly call for a change in approach from both organizations, as well as from bilateral agencies and national authorities. Greater attention would have to be paid to finding out what was already being done at district level in individual countries and what plans existed, rather than imposing priorities and targets. (2) District-level activities had so far not proved to be very attractive to donor agencies and JCHP might therefore wish to consider how countries and donor agencies might be persuaded to allocate more resources to such areas and how a portion of resources for specific programmes might be used to strengthen district health systems. (3) JCHP was urged to make additional suggestions concerning ways of enhancing related activities.

47. UNICEF/JCHP members drew attention to the following aspects. (1) The primary health care system should be the basis for health care as a whole, and its structure should be as indigenous to the native culture as possible. Developing countries were well placed to assist one another in that respect. (2) Consideration should be given to integrating several programmes at village level; in addition to the practical advantages, that would ensure that monitoring could take place simultaneously to attain common goals. (3) Community participation was important in order to avoid the community perceiving health structures as alien, underutilizing them and being reluctant to extend any financial support to them. Funding from the community should be sought for a primary health care system which it regarded as belonging to it and native to its culture. (4) Greater stress should be placed on the preventive aspect of primary health care with emphasis on health education, particularly for young people. (5) Any primary health care infrastructure should provide services for women and children at the same place and time as part of the basic minimum needs programme. (6) Programmes to be implemented between 1992 and 1995 should have precise goals by which to motivate donor agencies and international organizations. (7) It was important to distinguish between rural and urban areas within the context of district health systems. (8) Strategies for strengthening the management of district

[1] Document JCHP-SS/92.5.

health systems should be based on a cost-recovery rather than a cash and carry strategy. (9) The role of district administration in the context of the management of district health systems should be defined. (10) It should be borne in mind that when discussing the structures of health systems too much attention was still too often given to aspects such as buildings and health personnel; there should be greater awareness that people must be regarded as central - what they perceived good health to be, what they could do about their own health and how they could reach out for support and services in the community.

48. WHO/JCHP members recognized the need to strengthen management and suggested the inclusion of two further aspects: (1) the quality assurance of local health services and (2) the need for health systems research work.

49. The UNICEF Secretariat drew attention to the Universal Immunization Programme (UIP) Plus system in India and to the Bamako Initiative, as well as the recent evaluation of it in the context of a number of African countries, as areas in which it was possible to build. Experience had shown that funds must be retained at local level and managed there in order to strengthen community structures. The three main forms of financing of health systems at community and district level - user charges, flat rate assessments and prepayment schemes - were mentioned, as was the need to take the question of equity (and the need to avoid any stigma) into consideration. The need to ask what was wanted at the district level itself was stressed, as was the importance of providing epidemiological capacity at that level.

50. JCHP was informed that experience in integration of maternal and child health care and family planning had been obtained in a number of countries, although more certainly needed to be done. Steps were also being taken with respect to quality assurance - a relatively recent development; the "best district" concept had been introduced in a number of countries, involving qualitative and quantitative assessment of indicators as a means to improve overall performance at district level. A study group had recently looked into the question of district health systems in urban areas. Lastly, concerning financing methods, WHO was assisting countries to assess their own situation, although the ultimate decision was a political one to be taken by the country.

51. The Chairman concluded by observing that many major programmes, such as the Expanded Programme on Immunization and the programme on oral rehydration therapy, had emerged as a consequence of the earlier failure of primary health care to take hold in many developing countries. There had been a sense of frustration because, while efforts were being made to set up health systems, women and children continued to suffer and die from vaccine preventable and easily curable diseases. UNICEF and WHO were together involved in that vital area. Were it possible to issue an extreme general prescription in that respect, it would be that no organization would be permitted to introduce any health programme in any country unless it first laid down a foundation for a national health system or unless an effective health system already existed, since a solid system was essential in order to sustain any intervention at the country level. UNICEF and WHO had a role to play in that context, each with its own special skill. It was not enough to endorse common action alone. Together the two organizations must assist countries to lay the foundations for an effective health system and, at the same time, ensure that services were provided right down to the community level in such a way that interventions could be maintained. The current discussion was in its early stages and required further elaboration in practical terms to determine how UNICEF and WHO would play their respective parts. At the same time, linkage between the primary and secondary health care levels was essential, as primary health care could not stand on its own.

52. **Recommendations**

(1) JCHP recommends the following common action points for WHO and UNICEF support to the strengthening of district health systems, and submits them to the Executive Boards of WHO and UNICEF for their consideration and endorsement:

> (a) The district is the key level of the health system to implement, monitor and expand the health delivery system. Many lessons have been learned from national efforts to improve the management of district health systems, in many cases with support from WHO and UNICEF. The challenge for the future is for WHO and UNICEF to work together effectively and efficiently to further support the strengthening of district health systems through a variety of programme approaches, including the Bamako Initiative.

Country level action - participation and management

(b) **Policy analysis and promotion.** WHO and UNICEF should work with countries in the analysis of existing policies and programmes, with a view to developing a policy framework to support district health systems. Elements of the required framework include decentralization of health management to the district level, provision for community participation in health development, a strong essential drugs policy, development of appropriate cost-sharing mechanisms, and improved financial management systems. The analysis should ensure that all existing delivery structures, including those of the Expanded Programme on Immunization and the programme on maternal and child health and family planning, are reviewed and integrated into the district health system. External agencies are in a key position to cooperate in the provision of technical as well as financial resources to carry out such policy analysis. A variety of processes, which include involvement of national committees and working groups focused on specific issues, can be used to coordinate the reviews and the actions required.

(c) **Baseline assessment of progress in implementing primary health care at the district level.** WHO and UNICEF should work with countries to support and/or assist in sectoral reviews and planning in each of the four areas which have been identified for strengthening of primary health care:

(i) Health services delivery. The health system should be reviewed in terms of service content, organization and delivery strategies. Accessibility, coverage and quality of services should be examined, along with management capacity in such areas as planning and monitoring, supply and management information systems.

(ii) Community participation. Existing experiences should be examined to provide a picture of workable approaches for representation, control and responsibilities. Information should also be obtained on management skills and capacity at the community level, and community skills should be enhanced through such measures as functional literacy and numeracy.

(iii) Resource mobilization and allocation. To fully understand the resource requirements at the district level, information is needed on existing community resources and expenditures. The resource gap can be estimated through an assessment of health service needs and resource requirements, and thus permit an analysis of feasible alternatives for obtaining and managing additional resources.

(iv) Management support. The district health system's capacity and materials for in-service training and supervision, as well as the requirements for staff development support, should be ascertained. Estimates of available capacity for transport and for the procurement and distribution of drugs and supplies are needed as a basis on which to plan support to health workers in these areas.

(d) **Planning for the strengthening of district health systems.** At the district level, plans should be prepared based on the assessment of health service progress and problems. The planning process should include a prioritization of problems, a listing of corrective actions and the levels at which they should be taken, and the identification of steps to address the problems. A critical element of the plan will be the preparation of a budget which details the recurrent and capital costs of implementing the plan.

(e) **Support for training, supervision and logistics.** Based on the assessments of the gaps in technical and managerial skills of communities and district staff (see (c)(ii) above), WHO and UNICEF can assist in the development of training materials and the training of trainers to work with communities and health workers.

(f) **Support for monitoring, evaluation and operational research.** The development of district strategies and plans to address the needs identified in the assessment will necessitate the development of indicators for purposes of regular monitoring and evaluation. WHO and UNICEF should assist in the development of management information systems to facilitate these management processes, enabling comparative indicators to be reviewed across districts as a basis for monitoring the improvement of performance. Persistent problems or those that appear across several districts would warrant the design of operational studies to determine solutions.

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(g) **Planning and resource mobilization at the national level.** WHO and UNICEF should collaborate in the setting of national targets for strengthening district health systems, in terms of health units and districts providing effective health services, population coverage and health status improvements. National plans should be prepared, based on the individual district plans. The national plans should clearly indicate health system inputs and outputs and their phasing. The national plan for district health strengthening should be developed as part of the national plans of action, agreed to by countries at the World Summit for Children, detailing how the national goals for the 1990s will be achieved. The national plan will also indicate how WHO and UNICEF will support national actions under the district approach.

Global and regional level action

(h) **Support for national capacity building.** WHO and UNICEF should continue to enhance national capacity for strengthening of district health systems through various initiatives, including the Bamako Initiative. Intercountry workshops represent one vehicle for this effort. The workshops should address the different fields of joint activity identified above for the country level. In addition, streamlining and adaptation of training materials, and testing their use in different settings, will facilitate the training of district health staff and community representatives in management and technical skills. WHO and UNICEF should facilitate the gathering and dissemination of appropriate and tested staff training materials used by districts in different countries.

(i) **Advocacy and coordination.** WHO and UNICEF should systematically incorporate advocacy for district health systems into their discussions with government and external agencies. With governments, the organizations should stress fulfilment of the policy conditions for strengthening district services, in collaboration with other agencies engaged in these areas. In discussions with other international agencies, WHO and UNICEF should encourage involvement in support of district health systems, and should make efforts to coordinate these activities in order to ensure that district goals are most effectively pursued. WHO and UNICEF should also promote the development of alliances with and among nongovernmental organizations, in order to influence their strategies for support of district health systems.

(j) **Monitoring and evaluation.** WHO and UNICEF should bring together and disseminate the results of monitoring and evaluation studies carried out at the national level. The organizations should promote the documentation, exchange and adaptation of experiences with district health systems. Progress in district health system strengthening and the Bamako Initiative should be reviewed regularly by the two organizations, based on the monitoring data collected at national level and compared against the targets which have been set by countries.

(k) **Operational research.** WHO and UNICEF should promote operational research as an applied tool for strengthening management. It could be used for systematic examination of innovations in such areas as community financing, intersectoral action, management improvements, etc. Emphasis should be placed on finding practical solutions to problems which are common to many countries. The findings should be documented, disseminated and followed up.

(2) JCHP recommends that the above points form the basis for the beginning of discussions and planning in practical terms between UNICEF and WHO with a view to supporting countries in the management of their district health systems. The two organizations are requested to develop a specific plan of action and to report on this plan, along with the progress made in achieving it, to the next session of the JCHP.

VII. "BABY-FRIENDLY" HOSPITALS: A BREAST-FEEDING INITIATIVE

53. In introducing the background document,[1] it was stated that the "baby-friendly" hospital initiative was very recent but that, on the evidence of progress in recent months, it might well compete in respect of rapidity of achievement with the other World Summit goals. The process had started by identifying key countries in a

[1] JCHP-SS/92.6.

phased development. It had been facilitated by the agreement of the International Association of Infant Food Manufacturers to cooperate with WHO and UNICEF on the goal of ending free supplies of breast-milk substitutes to maternity facilities and hospitals by the end of 1992. As a result, agreement had been reached, with the full participation of all parties, to end distribution of free or low-cost supplies of breast-milk substitutes in Mexico, Bolivia and Thailand. There had also been a spill-over effect, as for example the agreement on a national code of marketing in Bolivia. Discussion had taken place on appropriate supporting activities by WHO and UNICEF, including investigation of the cost-effectiveness of "baby-friendly" hospitals. The technical process of designating such hospitals had been worked out and there had been a qualitative change in the level of cooperation between all concerned. The initiative had been developed in response to the Innocenti Declaration which had called for elimination of the constraints which made breast-feeding difficult, such as hospital practices. Other constraints were the slow progress of countries in giving effect to the International Code of Marketing of Breast-milk Substitutes and the need for legislation to enable working mothers to breast-feed. Nationals from 30 countries had been trained in breast-feeding and in lactation management, and resource centres had been established to improve knowledge and to focus on programmes to support women in breast-feeding. However, there was a need for better dissemination of factual information about breast-feeding to countries and to nongovernmental organizations. Within the previous six months, a World Alliance for Breastfeeding Action had been established to bring together all the nongovernmental organizations working in the field.

54. Mention was made of the need to continue to monitor information about mother's milk and the human immunodeficiency virus (HIV). It was stated that this issue had been reviewed both at the time of the Innocenti Declaration (August 1990) and later at a meeting in Ankara (June 1991) hosted by the International Pediatric Association. It was recommended that the benefits of breast-feeding and its possible relation to HIV should continue to be periodically evaluated. The Global Programme on AIDS continues its coordinating role in assessing this issue.

55. It was suggested that the initial focus in promoting and recognizing "baby-friendly" hospitals should concentrate on the successful implementation of the ten steps to successful breast-feeding[1] before expanding the concept to other areas of mother and child health care.

56. **Recommendation**

JCHP takes note of the following common action points and recommends their submission to the Executive Boards of UNICEF and WHO for consideration and endorsement.

WHO and UNICEF should:

(a) continue to mobilize various sectors of society globally to be aware of the critical importance of breast-feeding and act accordingly; these sectors include religious institutions, professional organizations, the infant food industry and community organizations;

(b) strengthen the technical capacity in countries to implement the "baby-friendly" hospital initiative through establishing lactation training and resource centres;

(c) support countries with programme guidelines to enable them to incorporate the "baby-friendly" hospital initiative in ongoing development of health and nutrition programmes;

(d) increase the flow of and access to factual information on all areas of infant and child feeding;

(e) strengthen and extend the existing network of WHO collaborating centres for training of trainers, development of training materials and research, as part of the "baby-friendly" hospital initiative;

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[1] Protecting, promoting and supporting breast-feeding: the special role of maternity services. A joint WHO/UNICEF statement. Geneva, WHO, 1989.

(f) further development, evaluation and widespread application of relevant indicators for infant and young child feeding, for programme monitoring, evaluation and planning, and for certifying a hospital as "baby-friendly";

(g) facilitate and encourage within-country dialogue and cooperation in support of the "baby-friendly" hospital initiative among the various interested parties, under the direction and guidance of national authorities;

(h) after sufficient experience has been gained with the "baby-friendly" hospital initiative, promote and technically support the extension of the practical application of the concepts of the "baby-friendly" hospital initiative to other aspects of infant and young child nutrition, child survival and maternal health, nutrition, safe motherhood and family planning.

VIII. THE ROLE OF UNICEF IN THE PROMOTION AND SUPPORT OF BREAST-FEEDING

57. In introducing the background document,[1] it was recalled that in its resolution 1991/22, the Executive Board of UNICEF had requested the Executive Director to propose to JCHP that a study should be undertaken to examine national and multinational corporations' marketing practices for infant food and how these practices affect the well-being of mothers and children and to report on progress to the 1993 Executive Board. The UNICEF Board had noted that since the adoption of the International Code of Marketing of Breast-milk Substitutes, new products had been introduced into the market which might not be covered by the Code and new marketing techniques had been used which also might not be covered. Several countries represented on the UNICEF Board wanted help in documenting these new developments so that countries could take appropriate action to protect breast-feeding. Since the UNICEF Board discussions there had been a number of developments, including a commitment by the International Association of Infant Food Manufacturers and its member companies to cooperate with WHO, UNICEF and governments to end the distribution of free and low-cost supplies of infant formula to maternity wards and hospitals by the end of 1992 in developing countries. WHO had developed a methodology, the Common Review and Evaluation Framework (CREF), to assist countries which so chose to review progress in the action taken to give effect to the principles and aim of the Code and had offered to provide technical and legal guidance to Member States, on request, on national legislation or other relevant action. In September 1991, 14 countries, which had used the CREF methodology to review and evaluate action taken to give effect to the Code, exchanged their experiences and made recommendations to WHO for follow-up action.

58. WHO noted that, in addition to those developments, the "baby-friendly" hospital initiative had stimulated action on the Code in several countries and WHO had received an increasing number of requests for technical cooperation on national action to give effect to the Code, to which it was responding. The CREF had proven to be a good technical methodology to assess progress by Member States. WHO intends to publish and distribute the CREF to all Member States and to offer further technical support.

59. The UNICEF Secretariat stated that information from some of their country representatives suggested that governments had indeed been encouraged through WHO and UNICEF technical assistance to develop national codes, but some countries still needed more updated information on those practices at the global level that had emerged since the Code was adopted 11 years ago. It was further pointed out that, although some advances had been made in the direction recommended by WHO and UNICEF, for various reasons the implementation of the Code had been slower than had been expected, and even in countries which had translated the Code into national legislation, that had made less difference than had been hoped.

60. On the other hand, the in-depth action taken by 14 countries revealed that once the methodology and the advantages of the exercise were explained to them, countries responded and showed great interest. Four other countries, which had been unable to undertake the exercise owing to time constraints, had nevertheless asked for continued support. The countries concerned had identified follow-up action on a country-by-country basis, adapting existing methodologies and guidelines to actual country situations. In addition, an article-by-article analysis of what all countries had done to implement the Code was available to Member States and the JCHP. A consolidated report on the Code had also been prepared. Participating countries frequently identified and

[1] Document JCHP-SS/92.7.

documented the problems that had been brought up in the UNICEF Board discussions. It was concluded that, in view of the availability of all the new information, it should perhaps be recommended that the two organizations should respond by alerting countries to the new developments in marketing practices, indicating to them how such practices affected breast-feeding and related to the Code. That information is particularly important for developing countries, to enable them to protect themselves against new trends. The adoption of national codes requires long legislative processes and, unless those countries are fully informed, breast-feeding will still be under threat by the time they have a protective law. Moreover, developing countries rightly consider that their scanty resources should not be invested in monitoring marketing practices, but rather in improving health services, through the "baby-friendly" hospital initiative.

61. **Recommendations**

(1) JCHP endorses, in principle, operative paragraphs 1 to 7 of UNICEF Executive Board resolution 1991/22 on the role of UNICEF in the promotion and support of breast-feeding[1] and recommends their endorsement by WHO and UNICEF.

(2) JCHP recognizes the need of a number of countries for additional information regarding marketing practices for breast-milk substitutes and recommends the dissemination of this information to help countries in developing national legislation or other suitable action related to implementation of the principles and aim of the International Code of Marketing of Breast-milk Substitutes.

(3) In this connection, and in regard to paragraph 6 of UNICEF Executive Board resolution 1991/22, JCHP recommends that future studies of marketing practices be conducted by countries, with the assistance of WHO and UNICEF. JCHP encourages the use of the new methodology of the Common Review and Evaluation Framework (CREF), *inter alia*, to support countries in making such reviews. It is understood that the UNICEF Executive Board resolution refers to breast-milk substitutes and not infant foods in a broader sense.

IX. DATE AND PLACE OF THE NEXT REGULAR SESSION OF JCHP

62. It was recommended that, with the consent of the Executive Boards of WHO and UNICEF, the next regular session of JCHP should be held in Geneva immediately following the ninety-first session of the WHO Executive Board in January 1993.

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[1] Economic and Social Council. Document E/1991/33: E/ICEF/1991/15, New York, 12 June 1991.

ANNEX 1

AGENDA

1. OPENING

1.1 Statements by the Director-General of WHO and the Executive Director of UNICEF
1.2 Election of Chairman and Rapporteurs
1.3 Adoption of agenda [JCHP-SS/92.1]

2. WORLD SUMMIT FOR CHILDREN: FOLLOW-UP ACTION

World Summit for Children: follow-up action by WHO and UNICEF [JCHP-SS/92.2]

Under this item JCHP will have before it a basic document outlining the follow-up action by WHO and UNICEF to the World Summit for Children. WHO emphasizes a holistic approach in response to World Health Assembly resolution WHA44.33 (May 1991), which recognizes that the Summit goals and Plan of Action are in accord with the global policy and strategy for health for all by the year 2000, based on primary health care. Accordingly Part I draws attention to the importance of adequate health infrastructures to facilitate and sustain programme implementation, and provides information on WHO's programme strategies, monitoring mechanisms and activities, in particular those undertaken in collaboration with UNICEF. In Part II, UNICEF's programme strategies and support measures are outlined, including the country-programming process, priority to Africa, UNICEF's role in the industrialized countries, monitoring mechanisms, advocacy and resource mobilization. These proposals were endorsed by the UNICEF Executive Board in decision 1991/10 (April 1991). An addendum to Part II outlines priority action points for collaboration between UNICEF and WHO. Parts I and II are drawn together in the Executive Summary which seeks the advice and/or endorsement by JCHP of the strategies and collaborative action proposed.

Background papers

Meeting vaccine needs for the EPI in the 1990s [JCHP-SS/92.3]

Response to the cholera epidemic: points for action [JCHP-SS/92.4]

The Executive Summary (in document JCHP-SS/92.2) also provides a link to the background papers on vaccine needs for the Expanded Programme on Immunization in the 1990s (JCHP-SS/92.3) and the response to the cholera epidemic: points for action (JCHP-SS/92.4). The problem posed by the rising cost of vaccines is brought to the attention of JCHP for its advice. Similarly, the outbreak of cholera in 1991 in Latin America and Africa clearly shows the effects of economic constraints in developing countries, and the visibility given to cholera could be used to promote oral rehydration therapy (ORT) and in general boost efforts to control diarrhoeal diseases which remain a major killer among children in these countries.

3. MANAGEMENT OF THE DISTRICT HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE

Management of the district health system based on primary health care [JCHP-SS/92.5]

At its twenty-eighth session in January 1991, JCHP recommended that WHO and UNICEF should continue to discuss the modalities for supporting countries in implementing primary health care within the structure of the national health care system and that this topic be discussed at the special session. The UNICEF Executive Board adopted decision 1991/12 which stresses the need for the quantitative health sector goals adopted by the World Summit for Children to be adapted at the country level to national needs and circumstances, and pursued through strategies integral to the development of sustainable health care systems. The joint document presented to JCHP outlines basic strategies for the improvement of the management of district health systems, to be adapted by countries to make them relevant and operational, and to ensure attainment of the Summit goals. Strategies relate to planning and delivery of health services, community

participation, resource mobilization and allocation, and management support. Common action points for WHO and UNICEF at country, regional and global level are proposed for JCHP's consideration.

4. OTHER MATTERS

4.1 Breast-feeding

(a) "Baby-friendly" hospitals: a breast-feeding initiative [JCHP-SS/92.6]

A new breast-feeding initiative, the "baby-friendly" hospital, was launched in July 1991. Maternity wards and hospitals applying the principles described in the joint WHO/UNICEF statement on breast-feeding and the role of maternity services[1] are being designated "baby-friendly" to call public attention to their support for sound infant-feeding practices. This document shows how the initiative could change the outlook of health professionals toward breast-feeding and elaborates criteria for certifying that a hospital or other institution was indeed "mother- and baby-friendly".

(b) The role of UNICEF in the promotion and support of breast-feeding [JCHP-SS/92.7]

In April 1991 the UNICEF Executive Board adopted decision 1991/22 which requests the Executive Director of UNICEF to propose to JCHP that a study be undertaken to examine national and multinational corporations' marketing practices for infant food and assess their impact on the well-being of mothers and children, and to report on progress to the UNICEF Executive Board in 1993. The proposal of the UNICEF Executive Board should be seen in the context of the recently completed evaluation in 19 countries of action taken on the Code and in the light of recommendations of the eighty-ninth session of the WHO Executive Board which precedes JCHP. This document therefore presents information which could be useful in deciding on further action.

4.2 Date and place of the next regular session of JCHP.

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[1] **Protecting, promoting and supporting breast-feeding: the special role of maternity services.** A joint WHO/UNICEF statement. World Health Organization, Geneva, 1989. Soon to be available in 27 languages.

ANNEX 2

LIST OF PARTICIPANTS

UNICEF Executive Board members

Miss Mira Seth
Chairman, Executive Board
Secretary, Department of Women and Child Development
India

Mr Frederick Ward
Chairman, Programme Committee
Director-General
Multilateral Branch, CIDA
Canada

Dr Martin Adouki
Permanent Representative to the United Nations Permanent Mission of the People's Republic of the Congo to the United Nations, New York

Dr Audrey Manley, **Rapporteur**
Deputy Assistant Secretary for Health
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United States of America

Dr Alfredo Toledo
Secretario Ejecutivo del Plan Caif
Presidencia de la Republica
Uruguay

Dr Suyono Yahya
Secretary to the Minister for People's Welfare
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Dr T. Hill, Senior Health Adviser
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Ms M. Kyenkya-Isabirye, Project Officer, Breastfeeding
Dr A. Paganini, Manager, Bamako Initiative
Dr J. Sherry, Senior Programme Officer, Programme Strategy
Mr Samir Basta, Director, Geneva Office
Dr C. Voumard, Senior Programme Officer, Geneva Office

Annex 2

WHO Secretariat

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Mr H. Dhillon, Director, Health Education (HED)
Mr H. Emblad, Director, Programme on Substance Abuse (PSA)
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Dr E. Goon, Director, Development of Human Resources for Health (HRH)
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Dr G. Torrigiani, Director, Communicable Diseases (CDS)
Dr J.L. Tulloch, Director, Diarrhoeal and Acute Respiratory Disease Control (CDR)